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IN THE SUPREME COURT OF THE UNITED STATES

ALBERTO GONZALES, ATTORNEY GENERAL, *et al.*,
Petitioners,

v.

STATE OF OREGON, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF *AMICI CURIAE* OF THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, CALIFORNIA CATHOLIC CONFERENCE, OREGON CATHOLIC CONFERENCE, WASHINGTON STATE CATHOLIC CONFERENCE; CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, AND LUTHERAN CHURCH-MISSOURI SYNOD IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI* [1]

The United States Conference of Catholic Bishops, California Catholic Conference, Oregon Catholic Conference, Washington State Catholic Conference, Catholic Health Association of the United States, and Lutheran Church-Missouri Synod join here as *amici curiae* in support of Petitioners, the Attorney General of the United States, *et al.* The Attorney General's conclusion that there is a difference between assisting suicide and managing pain, and that the former is not a legitimate medical purpose within the meaning of the Controlled Substances Act and regulations while the latter is, is not only eminently reasonable but also supported by longstanding medical practice and past interpretation of the Act. Enforcing the distinction leads to improvements in patient care. Blurring the distinction has been harmful to patients and jeopardized their care. Government does not serve the public interest or the common good by facilitating the killing of innocent people, regardless of their medical condition. The Attorney General's construction of federal law is reasonable and entitled to deference.

Individual statements of interest follow.

The United States Conference of Catholic Bishops is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Catholic Bishops in the United States. The Bishops of California, Oregon, and Washington State are also members of the California, Oregon,

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[1] Pursuant to this Court's Rule 37.6, counsel for a party did not author this Brief in whole or in part. No person or entity, other than the United States Conference of Catholic Bishops, made a monetary contribution to the preparation or submission of this Brief. The parties have consented to the filing of this Brief. Letters of consent are filed herewith.

and Washington State Catholic Conferences, respectively. Through the Conferences, the Bishops speak collegially on matters affecting the Catholic Church, its people, and society as a whole. The Conferences advocate and promote the pastoral teaching of the Church on many diverse issues, including the sanctity and dignity of human life. The ethical distinction made in law and medicine between legitimate treatment of pain and assisting suicide, a distinction that underlies the Attorney General's action in this case, has been influenced by concepts of intentionality and moral responsibility that have their foundation in the Church's centuries-old teaching. The Conferences are therefore especially well-suited to address this distinction and its importance to the integrity of the medical profession and to important societal interests in promoting health and relieving pain and suffering.

The Catholic Health Association of the United States ("CHA") is the national leadership organization of the Catholic health ministry, engaged in the strategic directions of mission, ethics and advocacy. This ministry, comprised of more than 2,000 nonprofit Catholic health care systems, sponsors, facilities, health plans, and related organizations, is rooted in and informed by a deeply held commitment to promote and defend human life and human dignity. CHA's interest in this case stems from its concern for the need to protect vulnerable persons; to ensure appropriate care for dying persons; to preserve the integrity of the health care professions; to strengthen the bonds of community; and to preserve the integrity of the Catholic health ministry.

The Lutheran Church-Missouri Synod (the "Synod") is the second largest Lutheran denomination in the United States. It has about 6,100 member congregations, with about 2.5 million baptized members. In 1995 the congregations of the Synod

passed a resolution expressing the Synod's objection "to medical personnel having any part in actively inducing death, even at the patient's request," and resolved "to speak against any attempt to legalize physician-assisted suicide." The Synod fully agrees with the Attorney General's conclusion that assisted suicide is not a legitimate medical purpose, but that pain management is. In a report published by the Synod's Commission on Theology and Church Relations, the Commission distinguished between assisted suicide ("euthanasia") and pain management: "Euthanasia, in its proper sense, is a synonym for mercy killing, which involves suicide and/or murder. It is, therefore, contrary to God's Law.... Administering pain-killing medications, even at the risk of shortening life, is permissible, since this does not entail the choice of death as either a means or an end."

SUMMARY OF ARGUMENT

"[A]ssisting suicide is not a 'legitimate medical purpose.'" 66 Fed. Reg. 56607, 56608 (Nov. 9, 2001). That simple declaration is at the root of this litigation. Indeed, it would appear to be a self-evident declaration. Medicine by its very definition aims to prevent illness, to heal, and to alleviate pain.[2] Taking a human life accomplishes none of these objectives. To say that it does creates an inherent contradiction, like saying that the legitimate practice of law includes helping clients break the law. The analogy is apt because helping to kill is precisely the opposite of what medicine is and does. Cooperating with killing positively impedes the overarching goods to which medicine is devoted. This is as true on a practical level as it is in principle, for recourse to legitimate care of the dying, including palliative care, is advanced when ethics and law forbid doctors to help

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[2] *See* Webster's New World Dictionary (3d College ed. 1988) (defining medicine as "the science and art of diagnosing, treating, curing, and preventing disease, relieving pain, and improving and preserving health").

patients take their own lives. Allowing intentional lethal acts will not make it easier for patients to obtain the medical care they need, but will only impede their ability to obtain such care. What virtually every state regards as a crime, indeed as a form of homicide, does not become "medicine" simply because the perpetrator is a doctor, the patient is terminally ill, or one state has decided to rescind its own criminal penalties for the act.

The Attorney General correctly concluded that assisting suicide is not a legitimate medical purpose, but that pain management is. 66 Fed Reg. 56607, 56608 (Nov. 9, 2001). It is apparent that the distinction between assisting suicide and managing pain was not always understood and appreciated by the lower courts hearing this case. *Oregon v. Ashcroft*, 192 F.Supp.2d 1077, 1079 (D. Or. 2002) (suggesting that assisted suicide serves the interest in "end[ing] … suffering"); *Oregon v. Ashcroft*, 368 F.3d 1118, 1123 n.5 (9th Cir. 2004) ("it is clear to us that controlled substances provide the best and most reliable means for terminally ill patients to painlessly take their own lives").

We file this brief to explain the ethical and legal basis for the Attorney General's twofold conclusion that assisted suicide is not a legitimate medical purpose for use of controlled substances while pain management is. In Part I, we explain the fundamental difference between treating pain and assisting suicide, addressing the misconception that assisting suicide is simply a means of treating pain. We also explain how this distinction, and the understanding of assisted suicide as being outside the scope of legitimate medical practice, is consistent with longstanding tenets of the medical profession and past interpretation and enforcement of the Controlled Substances Act, a fact overlooked by the lower courts. In Part II, we explain how recognizing the distinction between treating pain and assisting suicide, and prohibiting the latter, has led to significant improvements in

palliative care and in the ability of physicians to care for dying patients, while obliterating the distinction, as the opinion below would do, could have a deleterious impact on pain management and palliative care.

ARGUMENT

1. Assisting Suicide and Treating Pain Are Fundamentally Different.

Pain control and assisted suicide fundamentally differ in both intent and effect. A physician's intent in administering pain-killing drugs is simply "to ease his patient's pain," not to cause death. *Vacco v. Quill*, 521 U.S. 793, 802 (1997). A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.* at 802, quoting Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 367 (1996). This distinction has long been recognized in criminal law. If a patient dies after receiving palliative care, an attending physician is not liable for murder for he or she did not intend death. When a doctor accedes to a patient's request to provide the means of committing suicide, however, death is always the intention.

Assisted suicide and palliative care also have radically different consequences. Assisted suicide by definition is always deadly when it succeeds. Palliative care, however, does not kill people.

Indeed, at one time, concerns were voiced that pain medication might cause respiratory depression leading to a patient's death. "More recent experience … has shown that respiratory depression, although theoretically possible and

occasionally encountered, very seldom is of practical concern when physicians exercise care in adjusting dosages and observing patients for responses to medication." Howard Brody, M.D., *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, 82 Minn. L. Rev. 939, 947 (April 1998). Today the risk of respiratory depression resulting from pain management is "more myth than fact," for there is "little evidence that the use of medication to control pain hastens death." Susan Anderson Fohr, *The Double Effect of Pain Medication: Separating Myth from Reality*, 1 J. of Palliative Med. 315 (1998) (quoting the abstract).

In the April 1997 Supplement to its widely cited 1994 report on assisted suicide and euthanasia,[3] the New York State Task Force on Life and the Law likewise rejected the claim that aggressive pain management results in death from depression of respiration or other side effects:

> While high doses of morphine can depress respiration when administered to patients who have not developed tolerance to the drug, physicians who treat patients with morphine for the relief of pain increase the doses gradually, so that tolerance can develop.... [T]here appears to be no limit to tolerance when the drug is administered properly. The claim that the use of morphine at properly titrated levels "hastens" patients' deaths, based on the effects of high doses of morphine on patients who have *not* developed tolerance, is entirely unfounded.

[3] *E.g., Washington v. Glucksberg*, 521 U.S. 702, 719 (1997) (relying on the 1994 report).

IN THE MEDICAL CONTEXT 17 (April 1997 Supplement) (original emphasis) (internal quotation marks and citations omitted). Other authorities similarly note that when dosages are properly calibrated to relieve pain, death as a side-effect is extremely rare, if it occurs at all:

> As commonly used, pain medications rarely accelerate the patient's death. Patients using opioids chronically do not experience respiratory depressant side effects at doses that are effective in suppressing pain. Once the patient is habitually taking opioids, only a quite extraordinary dose would be lethal. Only for patients who have received no opioids is the respiratory depressant effect present at analgesic doses, and few dying patients are in this situation.

Felicia Cohn, Ph.D., and Joanne Lynn, M.D., "Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide," in THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE 238, 249 (Kathleen Foley, M.D., and Herbert Hendin, M.D., eds., 2002); *see also* Marcia Angell, M.D., *The Quality of Mercy*, 306 New Eng. J. Med. 98, 99 (Jan. 14, 1982) ("Addiction among patients who receive narcotics for pain is exceedingly unlikely; the incidence is probably no more than 0.1 per cent.... The incidence of serious respiratory depression in patients who receive narcotics for pain is similarly low. As tolerance develops to the analgesic effects of narcotics, so it does to the respiratory effects. No more than 1 percent of patients who receive narcotics for pain develop serious respiratory depression."); American Pain Society, PRINCIPLES OF ANALGESIC USE IN THE TREATMENT OF ACUTE PAIN AND CANCER PAIN 23 (3d ed. 1992) ("[R]espiratory depression is rare in patients who have been receiving chronic opioid treatment");

Michael H. Levy, M.D., *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1129 (Oct. 10, 1996) ("Appropriate titration of the opioid dose rarely results in respiratory depression or cardiovascular collapse"); Elizabeth Cassidy, *et al.*, "As Life Ends: Professional Care Givers on Terminal Care and Euthanasia," in EUTHANASIA AND ASSISTED SUICIDE: THE CURRENT DEBATE 52 (Ian Gentles, ed., 1995) ("[I]t is well known by practitioners in the field of terminal care that deaths from narcotics are extremely rare in terminal patients").

If death results, it is unintended. When, for example, a person undergoes surgery for a serious or life-threatening illness, the fact that she may die on the operating table obviously does not mean that her death was intended or that the surgeon should be charged with murder. The New York State Task Force made the same point:

> [T]he fact that morphine drips may accelerate patients' deaths in some cases does not make their use equivalent to assisted suicide or euthanasia. Just as a surgeon might undertake risky heart surgery knowing that the patient may die on the table, so the conscientious physician can risk suppressing the patient's respiratory drive and thus hastening death so long as she is pursuing a valid medical objective and there are no better (less risky) options at hand.

WHEN DEATH IS SOUGHT, at 17 (April 1997 Supplement) (internal quotation marks and citations omitted); *see also* Cohn & Lynn, *supra* at 249 ("Even if a physician's act may hasten death, the physician is not acting to ensure an earlier death").[4]

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[4]Similar differences in intent and causation undergird the difference between assisted suicide and withdrawal of life-sustaining treatment. The

Intentionality is important both to medicine and to law, and undergirds the ethical and practical distinctions at issue here.[5]

American Medical Association recognizes:

> In respecting a patient's decision to have treatment withheld or withdrawn, the physician is acting squarely within the historic parameters of the profession. The physician is fulfilling his or her role as someone who responds to the patient's needs by providing medical treatment.... Although the act of withholding or withdrawing medical treatment may lead to death, the intent of the physician in so acting is not to cause death, but to respect the patient's essential right to decide if and when to let the disease process take its course.
>
> Conversely, when the physician responds affirmatively to a request for help in committing suicide, the physician's intent is only to help the patient in taking his or her life. The physician thus acts with intent to kill.

Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association, *et al.*, as *Amici Curiae* in Support of Petitioners, at 20, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858).

[5]Medical ethics sometimes discusses the difference between the intended and unintended effects of a procedure in terms of the "principle of double effect." An action that unavoidably may have both a good effect and a bad effect is justifiable if the action: (1) is not itself immoral; (2) is intended only to cause the good effect, though the bad effect may be foreseen; (3) does not bring about the good effect only by means of the possible bad effect (*e.g.*, deliberately causing death to end pain, with the argument that dead patients cannot feel pain); and (4) is undertaken for a proportionately serious reason. Providing pain medication in dosages necessary to relieve intractable pain fulfills these criteria; euthanasia and physician-assisted suicide do not. Edmund Pellegrino, M.D., and Daniel Sulmasy, M.D., *The Rule of Double Effect: Clearing Up the Double Talk*, 159 Arch. Intern. Med. 545-50 (1999).

The principle of double effect has been accepted and used in medical practice for many years. One recent survey finds the principle so widely

The distinction between relieving pain and assisting suicide is also consistent with past interpretation and enforcement of the Controlled Substances Act. Well before the Attorney General issued his directive on assisted suicide in November 2001, the Drug Enforcement Administration ("DEA") had considered facilitating suicide to be inconsistent with "public health and safety" under the Controlled Substances Act. 21 U.S.C. § 823. In 1995, for example, the DEA denied an application for a Certificate of Registration in a case in which the registrant had prescribed 100 tablets of Darvocet to a patient who, a few days earlier, had made a serious suicide attempt. 60 Fed. Reg. 56354 (Nov. 8, 1995). The physician's conduct, which one expert likened to "handing [the patient] a loaded gun," facilitated the patient's suicide by overdose. *Id.* at 56355. Applying the Act's clear federal standard for denying such applications,[6] a standard that is not dependent on state law, the DEA concluded that "[t]he threat to the public health and safety" of the registrant's

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accepted among practicing British and American health professionals, particularly in the context of controlling pain and withdrawing life-sustaining treatment, that the authors conclude that those who criticize the principle may be "out of touch" with modern medicine. Donna L. Dickenson, *Are Medical Ethicists Out of Touch: Practitioner Attitudes in the US and UK Towards Decisions at the End of Life*, 26 J. Med. Ethics 254-60 (2000). Of course, "[t]he argument that [the principle of double effect] should be rejected out of hand simply because it originated with a particular religious tradition is completely unwarranted." Pellegrino & Sulmasy, *supra* at 549. It would be comparable to rejecting homicide laws because they happen to coincide with the Fifth Commandment. *Cf. Harris v. McRae*, 448 U.S. 297, 319 (1980) ("That the Judaeo-Christian religions oppose stealing does not mean that a State or the Federal Government may not, consistent with the Establishment Clause, enact laws prohibiting larceny.").

[6] 21 U.S.C. 823(f)(5) (requiring consideration of whether a practitioner has engaged in "conduct which may threaten the public health and safety" in deciding whether registration would be "inconsistent with the public interest").

prescribing practices "directly impacts upon the public interest." *Id.* at 56356. *See also* 55 Fed. Reg. 37579, 37580 (Sept. 12, 1990) (denying DEA registration of registrant whose prescriptions facilitated drug addiction ultimately leading to an attempted suicide); 59 Fed. Reg. 46063, 46065 (Sept. 6, 1994) (denying DEA registration where registrant's conduct included providing anabolic steroids to a patient who ten months earlier had attempted suicide).

The fundamental distinction between assisting suicide and relieving pain is also recognized elsewhere in federal law. Under the Assisted Suicide Funding Restriction Act of 1997 ("ASFRA"), Pub. L. No. 105-12, 111 Stat. 23 (April 30, 1997), federal funds may not be used to pay for items and services the purpose of which is to cause or assist in causing the suicide of any individual. By its express terms, nothing in ASFRA applies to, or imposes any limitation on, "the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason." 42 U.S.C. § 14402. In the words of a sponsor, ASFRA was designed to recognize "the critical difference between the administration of pain medication and physician-assisted suicide," even in the rare case where administering the level of medication necessary to relieve pain may have a "secondary effect" of hastening death. 143 Cong. Rec. S3260 (daily ed. April 16, 1997) (statement of Sen. McConnell).

In declaring its support for ASFRA, the American Medical Association emphasized the difference between taking life and relieving pain:

> The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides physicians. The AMA continues to stand by its ethical principle that physician-assisted suicide is fundamentally incompatible with the physician's role as healer and that physicians must instead aggressively respond to the needs of patients at the end of life.

143 Cong. Rec. S3258 (daily ed. April 16, 1997). Thus, since 1997, with the support of organizations representing the medical profession, all federal health programs have included pain management in the scope of legitimate medical procedures while explicitly excluding assisted suicide from that scope.[7]

In light of the widely- and long-recognized distinction between relieving pain and assisting suicide, the Attorney General properly concluded that pain management is a legitimate medical purpose for use of federally controlled drugs and that assisting suicide is not.

2. Enforcing the Difference Between Relieving Pain and Assisting Suicide Has Led to Improvements in Patient Care; Blurring the Distinction Threatens Patients and Patient Care.

There is evidence that when ethics and law maintain the distinction between palliative care and assisted suicide, and the latter is prohibited, patient care improves. Conversely, there is

[7]ASFRA confirmed the federal government's existing practice for, even prior to ASFRA's enactment, federal programs did not permit physicians to administer or prescribe medication for the purpose of ending a patient's life. *See* Brief of the United States as *Amicus Curiae* Supporting Petitioners at 2-3, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858).

evidence that when the distinction is blurred, as in the Netherlands and Oregon, patients and patient care suffer.

Failure to draw the distinction has a chilling effect on pain management and palliative care. The New York State Task Force writes:

> Just as conflating the refusal of treatment with assisted suicide is likely to undermine patients' ability to control their medical treatment, telling physicians that an unintended death resulting from the provision of necessary palliative treatment is a form of covert euthanasia is likely to result in many more patients experiencing unrelieved pain. As John Arras has pointed out, "many physicians would sooner give up their allegiance to adequate pain control than their opposition to assisted suicide and euthanasia." Characterizing the provision of pain relief as a form of euthanasia may well lead to an increase in needless suffering at the end of life.

WHEN DEATH IS SOUGHT 18 (April 1997 Supplement), quoting John Arras, *Physician-Assisted Suicide: A Tragic View*, 13 J. of Contemp. Health L. & Pol'y 361, 379 n.69 (Spring 1997). The same view is expressed by the authors of a study of attitudes about assisted suicide among oncologists. A reluctance to practice effective pain relief, the authors commented, "may be encouraged by proponents of euthanasia who have argued that there is no difference between increasing morphine for pain relief and euthanasia." Ezekiel J. Emanuel, M.D., *et al.*, *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 Annals of Internal Medicine 527, 530 (October 2000). Dr. Howard Brody

has suggested that pain management is best served by clearly distinguishing it from assisted suicide. He writes:

> Clinicians must believe, to some degree, in a form of the principle of double effect in order to provide optimal symptom relief at the end of life.... A serious assault on the logic of the principle of double effect could do major violence to the (already reluctant and ill-informed) commitment of most physicians to the goals of palliative care and hospice.

Brody, *supra* at 959. *See also* Pellegrino & Sulmasy, *supra* at 545 (the "rule of double effect ... encourages optimal care of the dying," while "[u]ndermining the rule ... has the potential to affect the care of the dying adversely").

The patients most likely to suffer from any confusion between controlling pain and assisting suicide are, of course, those who are already marginalized in the delivery and receipt of health care services. The New York State Task Force notes that any policy allowing assisted suicide

> will be implemented through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.

WHEN DEATH IS SOUGHT 4-5 (April 1997 Supplement); *see also* Cohn & Lynn, *supra* at 260 ("abuse [from legalization of assisted suicide] is a real risk, especially among those who are

elderly, frail, disabled, and economically disadvantaged").

Conversely, patient care improves in jurisdictions where the distinction between pain management and assisted suicide is recognized and the latter is prohibited. In his concurring opinion in *Glucksberg*, Justice Breyer cited a report of the House of Lords indicating that "the number of palliative care centers in the United Kingdom, where physician assisted suicide is illegal, significantly exceeds that in the Netherlands, where such practices are legal." 521 U.S., at 792, citing 2 House of Lords, Session 1993-1994 Report of Select Committee on Medical Ethics 113 (1994).[8] A Dutch hospice expert observes that while palliative care has developed rapidly in English-speaking countries, the acceptance and legalization of assisted suicide and euthanasia in the Netherlands have marginalized hospice and stifled the development of palliative care practices in that country. Zbigniew Zylicz, M.D., "Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician," in THE CASE AGAINST ASSISTED SUICIDE, *supra* at 122, 124, 141-143.[9]

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[8]Justice Breyer observed in oral argument in *Quill* that England, which forbids assisted suicide, has 185 palliative care centers, as compared with three such centers in Holland, which permits assisted suicide. *Vacco v. Quill*, No. 95-1858 (U.S.), Transcript of Oral Argument, *reprinted in* 12 Issues in Law and Med. 417, 437 (Spring 1997).

[9]A more recent report of a House of Lords committee taking up the question of end-of-life care does not dispel this negative judgment about the quality of palliative care in the Netherlands. Palliative care, the committee found, "is not recognized in [t]he Netherlands as a clinical speciality," and despite some increase in the number of palliative care units there, medical personnel "are mostly just continuing what they were doing – in the sense that there is no real specialist understanding, knowledge and practice of palliative care." House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, Volume 1: Report, 66 ¶¶ 183, 185 (April 4, 2005). There is also anecdotal evidence that the practice of

The picture in Oregon is similar. A 1999 survey of Oregon physicians who received requests for assisted suicide "gives us some picture of the inadequacy of palliative care consultation" there. Kathleen Foley, M.D., and Herbert Hendin, M.D., "The Oregon Experiment," in THE CASE AGAINST ASSISTED SUICIDE, *supra* at 144, 153-54. "In more than half of the 142 cases for which physicians supplied information, including eighteen of the twenty-nine patients who by that time had been given prescriptions for lethal medications and nine of the seventeen who had died from taking the prescribed medication, there was no palliative care intervention of any kind." *Id.* at 154. Significantly, physicians who assist suicide in Oregon "are not required … to be knowledgeable about how to relieve either physical or emotional suffering in terminally ill patients," nor does Oregon require "courses in pain management, palliative care, or the evaluation of a suicidal patient…." *Id.* at 145.

More recent studies show a significant statewide increase in reports of moderate to severe pain among patients in the last week of life after Oregon's law permitting physician-assisted suicide went into effect in October 1997. In Oregon hospitals, the prevalence of family-reported moderate to severe pain or distress in the last week of life rose from 33% in 1996-97 to 54% in 1998. Erik K. Fromme, M.D., *et al.*, *Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002*, 7 J. of Palliative Med. 431, 432 (2004). In non-hospital settings (private homes, nursing homes, foster care facilities, assisted

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euthanasia and assisted suicide in the Netherlands has inhibited the development of medical and palliative care skills in that country. In one reported case, a general practitioner did not know how to treat a patient with a gastrointestinal obstruction who was refusing euthanasia because in all previous cases the physician had "treated" patients with this condition by killing the patient. House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Volume II: Evidence, 449 (April 4, 2005).

living, and inpatient hospices), the prevalence of moderate to severe pain or distress for Oregon patients in the last week of life rose from 30.8% in the period November 1996-December 1997 to 48% in the period June 2000-March 2002. *Id.* at 432, 438.[10] Oregon residents in the latter period were "approximately twice as likely to be reported to be in moderate or severe pain or distress during the last week of their lives." *Id.* at 436.[11]

Assisted suicide has also increasingly become a substitute for treating or even evaluating problems such as depression, as suggested by the fact that in Oregon only 14% of those dying from a lethal overdose in 2001 had received any referral for psychiatric evaluation (compared to 29% for the preceding three years). Oregon Department of Human Services, Fourth Annual Report on Oregon's Death with Dignity Act 16 (Feb. 6, 2002). By 2003 and 2004, the last years for which statistics are available, the percentage of Oregon patients referred for psychiatric evaluation had dropped to 5 percent. Oregon Department of Human Services, Sixth Annual Report on Oregon's Death with Dignity Act 23 (March 10, 2004), and Seventh Annual Report on Oregon's Death with Dignity Act 24 (March 10, 2005).[12]

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[10]In Oregon, being female and young "were significantly associated with greater reported pain or distress," *id.* at 436, reflecting the New York State Task Force's prediction that legalization of physician-assisted suicide would put certain classes of people at greater risk. *See* discussion *supra* at 14-15.

[11]There is also evidence that the use of morphine for dying patients in Oregon has not kept pace with the national increase in morphine use. Susan W. Tolle, M.D., *et al.*, *Trends in Opioid Use Over Time: 1997 to 1999*, 7 J. of Palliative Med. 39 (2004) (finding that inpatient morphine use in Oregon "did not increase significantly for dying patients from 1997 to 1999") (quoting the abstract).

[12]Accessible at http://egov.oregon.gov/DHS/ph/pas/index.shtml (visited

On the other hand, jurisdictions that recognize a distinction between pain management and assisted suicide, and prohibit the latter, see positive effects on the use of drugs to relieve pain. Between 1992 and 2004, at least 12 states enacted new laws that ban intentionally assisting suicide, or that strengthen or clarify existing bans, with statutory language affirming the use of medications to control pain even when this may unintentionally increase the risk of death.[13] Data from the Drug Enforcement Administration on morphine use for these 12 states show that per capita use of morphine subsequently increased in every case, sometimes dramatically.[14] In these 12 states, the average increase in the use of morphine, the controlled substance most commonly used to alleviate pain in terminally ill patients, was 45 percent; in three states, morphine use doubled.

April 13, 2005).

[13] Iowa Code §§ 707A.1 to 707A.3; Kan. Stat. Ann. §§ 21-3406, 60-4403; Ky. Rev. Stat. Ann. §§ 216.302 to 216.308; La. Rev. Stat. Ann. § 14:32.12; Md. Ann. Code art. 27, § 416, repealed and reenacted without substantive change, Md. Code Crim. Law §§ 3-101 to 3-104; Ohio Rev. Code §§ 3795.01 to 3795.03; Okla. Stat. tit. 63, §§ 3141.1 to 3141.8; R.I. Gen. Laws §§ 11-60-1 to 11-60-5; S.C. Code Ann. § 16-3-1090; S.D. Codified Laws §§ 22-16-37.1 to 22-16-37.7, transferred to Chapter 34-12D by 2005 S.D. Laws, ch. 120 (SB 43); Tenn. Code Ann. § 39-13-216; Va. Code Ann. § 8.01-622.1.

[14] Drug Enforcement Administration, U.S. Department of Justice, Statistics on Individual State Consumption of Morphine (on file with the Subcommittee on the Constitution of the House Committee on the Judiciary). *See also* HANDBOOK OF PAIN RELIEF IN OLDER ADULTS: AN EVIDENCE-BASED APPROACH 193 (F. Michael Gloth, M.D., ed., 2004) (noting that "in every state that had passed such legislation [distinguishing between relieving pain and assisting suicide, and prohibiting the latter], there was an increase in the legitimate prescription of opioids and other strong medications used for pain control").

Data from the 12 states,[15] showing per capita use of morphine (expressed in grams per 100,000 people) in the years before and after enactment of a law against assisted suicide, are as follows:

Iowa – passed law in 1996 (took effect July 1996)

1995 – 935 g – 30th among states
1996 – 1,221 – 28th
1997 – 2,207 – 26th
1998 – 2,029 – 38th

Percentage change in morphine use: +136%.[16]

Kansas – passed law in 1998 (took effect July 1998)

1997 – 2,047 g – 35th
1998 – 2,016 – 39th
1999 – 2,179 – 32nd
2000 – 2,600 – 27th

Percentage change in morphine use: +6%.

Kentucky - passed law in 1994 (took effect July 1994)

1993 – 1,388 g – 11th
1994 – 1,624 – 6th
1995 – 1,462 – 4th
1996 – 1,673 – 7th

Percentage change in morphine use: +5%.

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[15] *Id.*

[16] All percentage changes shown are from the year before, to the year after, the newly enacted legislation's effective date.

Louisiana – passed law in 1995 (took effect June 1995)

1994 – 843 g – 41st
1995 – 786 – 45th
1996 – 1,058 – 37th
1997 – 1,845 – 42nd

Percentage change in morphine use: +26%.

Maryland – passed law in 1999 (took effect October 1999)

1998 – 2,858 g – 16th
1999 – 2,990 – 15th
2000 – 3,233 – 14th

Percentage change in morphine use: +13%.

Ohio – passed law in 2002 (took effect March 2003)

2001 – 2,586 – 37th
2002 – 3,105 – 37th
2003 – 3,874 – 32nd
2004 – 4,822 – 26th

Percentage change in morphine use: +55%.

Oklahoma – passed law in 1998 (took effect November 1998)

1997 – 2,097 g – 31st
1998 – 2,186 – 30th
1999 – 2,137 – 34th
2000 – 2,624 – 26th

Percentage change in morphine use: +2%.

Rhode Island – passed law in 1996 (took effect July 1996)

1995 – 928 g – 33rd
1996 – 966 – 46th
1997 – 2,454 – 18th
1998 – 2,480 – 24th

Percentage change in morphine use: +164%.

South Carolina – passed law in 1998 (took effect June 1998)

1997 – 1,457 g – 51st
1998 – 1,625 – 49th
1999 – 1,659 – 49th
2000 – 2,055 – 45th

Percentage change in morphine use: +14%.

South Dakota – passed law in 1997 (took effect July 1997)

1996 – 978 g – 45th
1997 – 2,132 – 30th
1998 – 1,896 – 43rd
1999 – 1,880 – 43rd

Percentage change in morphine use: +94%.

Tennessee – passed law in 1993 (took effect July 1993)[17]

1992 – 1,180 g – 16th
1993 – 1,417 – 9th
1994 – 1,544 – 8th
1995 – 1,407 – 7th

Percentage change in morphine use: +31%.

Virginia – passed law in 1998 (took effect July 1998)

1997 – 2,007 g – 37th
1998 – 2,106 – 33rd
1999 – 2,401 – 27th
2000 – 2,687 – 28th

Percentage change in morphine use: +20%.

During the same period, 1992 to 2004, three other states passed laws against assisted suicide that did not include language affirming pain control.[18] Even in those three states, per capita use of morphine tended to stay about the same or to increase slightly. Morphine use rose by an average of 3 percent. This suggests that prohibiting assisted suicide generally does not have a "chilling effect" on legitimate pain control, but ideally should be accompanied by an explicit affirmation of the legitimacy of pain management (like the affirmations included in ASFRA and

[17]In 2004, Tennessee ranked highest among all states – 12,458 grams of morphine per 100,000 people. Second highest was Arizona (12,395 grams per 100,000 people), which also prohibits assisted suicide by statute. Ariz. Rev. Stat. § 13-1103.

[18]Ga. Code Ann. § 16-5-5; Ill. Comp. Stat. ch. 720, § 5/12-31; Mich. Comp. Laws § 750.329a.

the Attorney General's November 2001 directive).

The three states are as follows:

Georgia – passed law in 1994 (took effect July 1994)

1993 – 1,029 g – 28th among the states
1994 – 937 – g – 33rd
1995 – 838 – g – 39th
1996 – 1,030 g – 39th

Percentage change in morphine use (from year before enactment to year after): -19%.[19]

Illinois – passed law in 1993 (took effect January 1993)

1992 – 811 g – 40th among states
1993 – 872 – 39th
1994 – 880– 46th
1995 – 822 – 40th

Percentage change in morphine use: +9%.

Michigan – passed law in 1998 (took effect September 1998)

1997 – 2,251 – g – 24th
1998 – 2,540 – 23rd
1999 – 2,700 – 19th
2000 – 2,957 – 23rd

Percentage change in morphine use: +20%.

[19]A year later, morphine use returned to its 1993 level.

It would be a mistake to turn away from the import of this overwhelming evidence. The data clearly indicate that, if assisting terminally ill persons is our principal concern, removing barriers to effective administration of palliative care and raising barriers to assisted suicide work best. The Attorney General's decision promotes proper assistance to the terminally ill as reflected in the data presented here.

CONCLUSION

The Attorney General was correct in finding that assisted suicide is not a legitimate medical practice under the Controlled Substances Act, and in clearly distinguishing this practice from the use of controlled substances to manage pain. Accordingly, the decision of the Court of Appeals should be reversed and the injunction vacated.

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